DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/24/10

FORM APPROVED
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED REGIONAL MEDICAL CENTER NURSING HOME	1001 MCARTHUR DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the corridor doors. The findings included: During the facility tour on 6/7/10 the following deficiencies were noted and verified by the Assistant Director of Maintenance. At 9:50 AM, observation of the physical therapy office door revealed the door did not close with-in the frame. National Fire protection Association (NFPA). 101, 8.3.4.3	K 018	K018 On 6/21/10, Maintenance personnel placed weather strip on the door frame and adjusted the door latch. All residents have the potential to be affected in the event of a fire due to the door in the physical therapy department not latching properly. The Maintenance Supervisor will in-service all maintenance staff regarding the importance of doors closing properly. The Administrator or her designee will monitor the corrective action to ensure effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to monitor if any doors do not close properly. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop and action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services and the Activity Director and others as indicated.	7/23/1
K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Hopkins — TITLE: Administrator — (X6) DATE: 6/24/10

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ...s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...gram participation.

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K 064 SS=E	Continued From page 1 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the fire extinguishers. The findings included: During the facility tour on 6/7/10 the following deficiencies were noted and verified by the Assistant Director of Maintance. At 10:00 AM, observation of the boiler room and the HVAC room revealed the fire extinguishers were blocked with equipment. National Fire protection Association (NFPA). 10, 1.6.3	K 064	K064 On 6/9/10, Maintenance personnel removed the equipment that blocked the fire extinguishers in the HVAC room and the boiler room. All residents have the potential to be affected in the event of a fire due to the fire extinguishers being blocked. On 6/25/10, maintenance employees will be in-serviced on equipment not blocking fire extinguishers by the Maintenance Supervisor. The Administrator or her designee will monitor the corrective action to ensure effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to monitor if any fire extinguishers are blocked. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services and the Activity Director and others as indicated.	7/23/1
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.	K 135	K135 On 6/7/10, maintenance personnel removed the can of gas in the maintenance shop. All residents have the potential to be affected in the event of a fire. On 6/25/10, maintenance employees will be	7/23/10

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K 135	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the combustible liquid. The findings included: During the facility tour on 6/7/10 the following deficiencies were noted and verified by the assistant Director of Maintenance. At 10:15 AM, observation of the maintenance shop revealed can of gas stored in the room. National Fire Protection Association (NFPA). 30, 4.4.3.6	K 135	in-serviced on proper storage of flammable and combustible liquids. The Administrator or her designee will monitor the corrective action to ensure effectiveness of this action by performing random walking rounds throughout the maintenance shop five times per week times four weeks. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop and action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services and the Activity Director and others as indicated.	7/23/10
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the no smoking signs. The findings included: During the facility tour on 6/7/10 the following deficiencies were noted and verified by the Assistant Director of Maintenance. At 9:35 AM, observation of the Nurses station revealed a cylinder of oxygen stored and no precautionary sign posted. National Fire Protection Association (NFPA). 99, 8.6.4.2	K 141	K141 On 6/7/10, the cylinder of oxygen at the nursing station was removed by the Assistant Administrator. All residents have the potential to be affected in the event of a fire or explosion due to an oxygen tank. All employees will be in-serviced on 6/24/10 and 6/25/10 regarding proper storage of oxygen tanks. The Administrator or her designee will monitor the corrective action to ensure effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to monitor proper storage of oxygen cylinders. If no further issues are identified	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

cont'd K141

random walking rounds will occur weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated

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K 147	Continued From page 3 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the electrical system. The findings included: During the facility tour on 6/7/10 the following deficiencies were noted and verified by the Assistant Director of Maintenance. At 9:40 AM, observation of the 400 hall bath revealed a broken light cover. National Fire protection Association (NFPA). 70, 110-12 At 10:05 AM, observation of the boiler room revealed the electrical panels were blocked with equipment. NFPA 70, 110-26(a) At 10:30 AM, observation of the Kitchen area revealed not all of the electrical outlets were ground fault circuit interrupters (GFCI). NFPA 70, 517-20	K 147	K147 1 Maintenance personnel replaced the broken light cover on the 400 hall bath on 6/9/10. 2 The equipment blocking the electrical panels in the boiler room was removed on 6/9/10 by maintenance personnel. 3 The electrical outlets in the kitchen were changed to GFCI as required for compliance on 6/10/10 by maintenance personnel. Since all electrical outlets have been checked and changed to GFCI as required for compliance, no further systematic change is needed. All residents have the potential to be affected in the event of a fire or electrical outage. Maintenance employees will be in-serviced on 6/25/10 regarding properly maintaining the electrical system on 6/25/10. Administrator or their designee will monitor the corrective action to ensure the effectiveness of this action by performing random walking rounds throughout the facility five times per week times four weeks to ensure no electrical panels are blocked and proper maintenance of the electrical system. If no further issues are identified random walking rounds will occur weekly to ensure compliance. The results of this monitoring will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	7/03